DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Form Approved
OMB No. 0938-0193

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**
**FOR: HEALTH CARE FINANCING ADMINISTRATION**

| TRANSMITTAL NUMBER | STATE |
|---|---|
| 92-32 | Missouri |

PROGRAM IDENTIFICATION: Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROPOSED EFFECTIVE DATE: October 1, 1992

TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

FEDERAL REGULATION CITATION: 42 CFR 447

| NUMBER OF THE PLAN SECTION OR ATTACHMENT | NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT |
|---|---|
| Attachment 4.19-A<br>Pages 17, 21 through 24 (new), and<br>Appendix A pages 1 through 4 (new). | Attachment 4.19-A Page 18 |

SUBJECT OF AMENDMENT: Inpatient Hospital Services Reimbursement Plan change implemented to be effective during the October - December, 1992 quarter. These changes establish the Federal Reimbursement Allowance (FRA) payment methodology.

GOVERNOR'S REVIEW (Check One)

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

SIGNATURE OF STATE AGENCY OFFICIAL

TYPED NAME: Gary J. Stangler

TITLE: Director, Department of Social Services

DATE: 12/29/92

RETURN TO:
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500

**FOR REGIONAL OFFICE USE ONLY**

| DATE RECEIVED | DATE APPROVED |
|---|---|
| 12-30-92 | JUN 06 2001 |

PLAN APPROVED – ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/92

SIGNATURE OF REGIONAL OFFICIAL

TYPED NAME: Thomas W. Lenz

TITLE: ARA for Medicaid & State Operations

REMARKS:

SPA CONTROL
Date Submitted 12/29/92
Date Received 12/30/92

cc: Martin/Vadner/Waite/CO

Form HCFA-179 (3/80) (Formerly PCO-11) Submit 6 Copies.

Appendix A

Federal Reimbursement Allowance (FRA). FRA shall be assessed as described in this section.

A. Definitions.

1. Hospital -- A place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of three or more non-related individuals suffering from illness, disease, injury, deformity or other abnormal physical conditions; or a place devoted primarily to provide for not less than twenty-four hours in any week, medical or nursing care for three or more non-related individuals. The term "hospital" does not include convalescent, nursing shelter, or boarding homes as defined in chapter 198, RSMo.

2. Engaging in the business of providing inpatient health care -- Accepting payment for inpatient services rendered.

3. Base Cost Report -- desk-reviewed Medicare/Medicaid cost report for the latest hospital fiscal year ending during calendar year 1990. (For example, a provider has a cost report for the nine (9) months ending 9/30/90 and a cost report for the three (3) months ending 12/31/90.) If a hospital's "Base Cost Report" is less than or greater than a 12 month period, the date shall be adjusted, based on the number of months reflected in the "Base Cost Report" to a 12 month period.

4. Contractual Allowances -- Difference between established rates for covered services and the amount paid by third party payors under contractual agreements.

5. State Base Percentage -- hospital donations collected during state fiscal year 1992, divided by the non-federal share of the total amount expended under the state plan during state fiscal year 1992.

6. Fiscal period -- 12 month reporting period determined by each hospital.

7. Department -- Department of Social Services.

8. Director -- Director of the Department of Social Services.

9. Division -- Division of Medical Services, Department of Social Services.

B. Each hospital, except public hospitals which are operated primarily for the care and treatment of mental disorders and any hospital operated by the Department of Health, engaging in the business of providing inpatient health care in Missouri shall pay a federal reimbursement allowance (FRA). The FRA shall be calculated by the Department of Social Services.

1. The FRA shall be calculated as follows: Total number of inpatient days reflected on each individual hospital's "Base Cost Report" multiplied by SFY 1993 projected Medicaid expenditures multiplied by State Base percentage minus donations under the uncompensated care plan, divided by total days reflected by all hospitals' Base Cost Reports. This calculation works out to be $34.79199 per inpatient hospital day from the 1990 base cost report.

2. If a hospital does not have a "Base Cost Report" the information required to calculate the FRA shall be estimated using the following criteria:

   A. Hospitals required to pay the FRA shall be divided in quartiles based on total beds;

   B. Each factor in the FRA calculation and the Medicaid/Medicare contractual payment shall then be individually summed and divided by the total beds in the quartile to yield an average bed day; and

   C. Finally the number of beds for the hospital without the "Base Cost Report" shall be multiplied by the average per bed.

C. Each hospital shall submit to the Department of Social Services a statement that accurately reflects:

1. If the hospital is publicly or privately owned;

2. If the hospital is operated primarily for the care and treatment of mental disorders;

3. If the hospital is operated by the Department of Health; and

4. If the hospital accepts payment for services rendered.

D. The Department of Social Services shall prepare a confirmation schedule of the information from each hospital's third prior year cost report and provide each hospital with this schedule.

1. This schedule shall include:

   A. Provider name;
   B. Provider number;
   C. Fiscal period;
   D. Total number of licensed beds;
   E. Total inpatient days;
   F. Total cost of contractual allowance for Medicare;
   G. Total cost of contractual allowance for Medicaid.

2. Each hospital required to pay the federal reimbursement allowance shall review this information and provide the Department of Social Services with correct information, if the information supplied by the Department of Social Services is incorrect, or affirm the information is correct within fifteen (15) days of receiving the confirmation schedule.

3. Each hospital may request that their federal reimbursement allowance be offset against any Missouri Medicaid payment due. Assessments shall be allocated and deducted over 17 Medicaid payrolls from October 15, 1992 through June 30, 1993.

4. The federal reimbursement allowance owed or, if an offset has been requested, the balance due, if any, after such offset, shall be remitted by the hospital to the Department of Social Services on a twice monthly basis, on the first and fifteenth of each month beginning October 15, 1992. The remittance shall be made payable to the director of the Department of Revenue. The amount remitted shall be deposited in the state treasury to the credit of the Federal Reimbursement Allowance Fund.

E. The Director of the Department of Social Services shall notify each hospital of the annual amount of its federal reimbursement allowance on or before October 1, 1992 and on or before the first day of May of each year thereafter.

F. In accordance with sections 208.156, RSMo (1986) and 62.055 RSMo (Cum. Supp. 1991), hospitals may seek a hearing before the Administrative Hearing Commission from a final decision of the Director, the Department or Division.

XV. Inpatient Psychiatric Services

A. Effective for admissions beginning on or after January 1, 1990, certain psychiatric services will be reimbursed at the lower of the hospital's Title XIX per diem rate or an inpatient psychiatric per-diem of $277. This limitation will apply to all hospitals with a valid Title XIX participation agreement.

B. The inpatient psychiatric per-diem is based on 110% of the 1988 weighted average cost for in-state, free-standing, non-state operated psychiatric units. The inpatient psychiatric rate will be adjusted by the inflation factor described in subsection (1)(F) granted on or after January 1, 1990.

C. The following diagnosis codes will be subject to the inpatient psychiatric per-diem: Diagnosis code range 290-316, Mental Disorders,except for codes 290-290.9, 293-293.9, 294-294.9, 306-306.9, 310-310.9 & 316.

D. Effective February 15, 1990 through November 30, 1990, urban hospitals subject to state and federal taxes who are disproportionate share hospitals with a profit margin of less than three percent (3%) and with government sponsored days in excess of sixty-five percent (65%), excluding newborn days, and who provide both obstetrical services and psychiatric services shall be exempt from the inpatient psychiatric services limitation specified in subsection XV.A.

E. The inpatient psychiatric per diem cap, effective for admissions on and after October 1, 1992, will be rebased using the 1990 weighted average cost for in-state, free standing, non-state operated psychiatric units. The 1990 weighted average cost of $326.37 was trended for State Fiscal Year 1993 by 2.34% plus $10.65. The cap is $344.66 effective for admissions on or after October 1, 1992.

XIX. Medicaid/Medicare Contractual Payment (MMCP). A Medicaid/ Medicare Contractual Payment shall be provided to hospitals that have a current Title XIX (Medicaid) provider agreement with the Department of Social Services, except those hospitals that receive a "Safety Net Adjustment" as defined in Section XVIII.

A. Definitions. As used in this subsection:

1. Medicaid Contractual Adjustment -- medicaid contractual allowance reported on the base cost report adjusted for hospital specific cost to charge ratio.
2. Medicare Contractual Adjustment -- medicare contractual allowance reported on the base cost report adjusted for hospital specific cost to charge ratio and multiplied by fourteen and one half percent (14.5%).

3. Base Cost Report -- desk-reviewed Medicare/Medicaid cost report for the latest hospital fiscal year ending during calendar year 1990. (For example, a provider has a cost report for the nine (9) months ending 9/30/90 and a cost report for the three months ending 12/31/90 the second cost report is the base cost report). If a hospital's "Base Cost Report" is less than or greater than a 12 month period, the date shall be adjusted, based on the number of months reflected in the "Base Cost Report" to a 12-month period.

4. Medicaid/Medicare Payment Cap -- Medicaid Contractual Adjustment added to Medicare Contractual Adjustment divided by total inpatient hospital days from the base cost report for each hospital. This yields a per day cost of the Medicaid and Medicare contractual adjustment. The cost per day for each hospital is ranked from lowest to highest cost. The Medicaid/Medicare Payment Cap is established at the 15th percentile;

5. Children's hospital - An acute care hospital operated predominately for the care or treatment of children under the age of eighteen (18) and which has designated in its licensure application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit at defined in 13 CSR 30-20.021(4)(F).

6. Proprietary, disproportionate share hospital - A for-profit hospital which qualifies as disproportionate share in accordance with section VI.

B. The Medicaid/Medicare Contractual Payment for each qualifying hospital shall be the lower of --

1. Medicaid Contractual Adjustment added to the Medicare Contractual Adjustment; or

2. (Medicare/Medicaid Payment Cap multiplied by total inpatient hospital days from the 1990 cost report) plus (UCACI Adjustment as defined in Section XVI for State Fiscal Year 1993 multiplied by a UCACI adjustment factor.

C. UCACI adjustment factor. The UCACI adjustment factor shall be fifteen percent (15%), unless specifically provided for within this subsection.

1. The UCACI adjustment factor shall be sixteen percent (16%) for proprietary, disproportionate share hospitals.

2. The UCACI adjustment factor shall be twenty-three percent (23%) for children's disproportionate share hospitals.

D. If a hospital does not have a "Base Cost Report" the information to calculate the Medicaid/Medicare Contractual Payment shall be estimated using the following criteria:

1. Hospitals entitled to a Medicaid/Medicare Contractual Payment shall be ranked from least to greatest number of inpatient hospital beds divided into quartiles;

2. Each factor in the Medicaid/Medicare Contractual Payment calculation shall then be individually summed and divided by the total beds in the quartile to yield an average per bed; and

3. Finally the total number of inpatient hospitals beds for the hospital without the "Base Cost Report" shall be multiplied by the average per bed to determine each factor.

E. Payments will be allocated and paid over the 17 Medicaid payrolls from October 15, 1992 through June 30, 1993.

F. Adjustments provided under this section shall be considered reasonable costs for purpose of the determinations described in paragraph V.D.2.

*Substitute per letter dated 09-28-00 *



XX. Effective October 1, 1992, each general plan hospital shall receive a Medicaid per diem rate, effective for admissions on or after October 1, 1992, based on its general plan (GP) rate compiled in accordance with Subsection XX.A. Each disproportionate share hospital shall receive a rate compiled in accordance with Subsection XX.B.

A. The general plan rate shall be the lower of the most current Title XVIII Medicare rate or the general plan per diem determined from the third prior year desk reviewed cost report in accordance with the following formula:

$$\text{GP Per Diem} = \frac{(OC * TI)}{MPD} + \frac{CMC}{MPDC}$$

1. OC - The Operating Component is the hospital's Total Allowable Cost (TAC) less CMC.

2. CMC - The Capital and Medical Education component of the hospital's TAC.

3. MPD - Medicaid Inpatient Days.

4. MPDC - MPD as defined previously with a minimum utilization of sixty percent (60%) as described in paragraph (5)(C)4.

5. TI - Trend Indices. The Trend Indices are applied to the operating component of the per diem rate. The trend indices for the third prior fiscal year will be used to adjust the Operating Component to a common fiscal year of June 30.

6. The general plan per deim shall not exceed the average Medicaid inpatient charge per diem as determined from the third prior year desk reviewed cost report and adjusted by the Trend Indices.

B. Disproportionate Share (DS) Rate. The Disproportionate Share rate in effect September 30, 1992 shall be adjusted by the state fiscal year 1993 trend index which shall be applied one-half to the individual hospital operating component and one-half based on the statewide average per diem rate as of June 30, 1992.

C. Trend Indices. Trend indices are determined based on the four quarter average DRI Index for PPS - Type Hospital Market Basket as published in "Health Care Costs" by DRI/McGraw-Hill.

1. The Trend Indices are:

   A. State fiscal year 1990 - 5.30%
   B. State fiscal year 1991 - 5.825%
   C. State fiscal year 1992 - 5.33%
   D. State fiscal year 1993 - 4.68%

2. The trend indices for the third (SFY-90) through first (SFY-92) prior fiscal year are applied as a full percentage to the operating component (OC) of the per diem rate. The trend indices for the current state fiscal year (SFY-93) is applied one-half to the individual hospital operating component and one-half time the statewide average weighted per diem rate as of June 30, 1992.

**INSTITUTIONAL STATE PLAN AMENDMENT**
**ASSURANCE AND FINDING CERTIFICATION STATEMENT**

STATE: Missouri TN - 92-32

REIMBURSEMENT TYPE: Inpatient hospital X

PROPOSED EFFECTIVE DATE: October 1, 1992

A. State Assurances and Findings. The State assures that is has made the following findings:

1. 447.253 (b) (1) (i) - The State pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. _____

2. With respect to inpatient hospital services - -

   a. 447.253 (b) (1) (ii) (A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. _____

   b. 447.253 (b) (1) (ii) (B) - If a state elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861 (v) (1) (G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861 (v) (1) (G) of the Act. _____

   If the answer is "not applicable," please indicate:

   _____



App

JUN 06 2001

c. 447.253 (b) (1) (ii) (C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality. _____

4. 447.253 (b) (2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

a. 447.272 (a) - Aggregate payments made to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. _____

b. 447.272 (b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) - - when considered separately - - will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. _____

If there are no State-operated facilities, please indicate "not applicable:"

_____

c. 447.272 (c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42CFR 447.296 through 447.299.

d. Section 1923 (g) _ DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923(g) of the Act. _____

B. State Assurances. The State makes the following additional assurances:

1. For hospitals - -

a. 447.253 (c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital -indebtedness, return on equity )if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

3. 447.253 (e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.

4. 447.253 (f) - The State requires the filing of uniform cost reports by each participating provider.

5. 447.253 (g) - The State provides for periodic audits of the financial and statistical records of participating providers.

6. 447.253 (h) - The State has complied with the public notice requirements of 42 CFR 447.205.

Notice published on: Sept. 30, 1992
If no date is shown, please explain:

7. 447.253 (i) - The State pays for inpatient hospital services using rates determined in accordance with the methods and standards specified in the approved State plan.

C. Related Information

1. 447.255 (a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: Hospital

**For hospitals**: The Missouri Hospital Plan includes DSH payments in the estimated average rates. However, the DSH payments included in the estimated average rates do not represent the total DSH payments made to hospitals under the Missouri Medicaid Plan.

RH-DSH included

Estimated average proposed payment rate as a result of this amendment:
$ 579.14

Average payment rate in effect for the immediately preceding rate period:
$491.75

Amount of change: $87.39 Percent of change: 17.77%

Estimated Out-of-state average payment rate as a result of this amendment:
$ 313.38

Estimated Out-of-state average payment rate immediately preceding this amendment: $ 344.9

Amount of change: $31.52 Percent of change: 10.06%

2. 447.255 (b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

(a) The availability of services on a statewide and geographic area basis:
This amendment will not effect the availability of short-term or long-term services.

(b) The type of care furnished: This amendment will not effect hospital services furnished to Medicaid eligibles.

(c) The extent of provider participation: This amendment will assure recipients have reasonable access taking into account geographic location and reasonable travel time to inpatient hospital services.

(d) For hospitals - - the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs:
It is estimated that disproportionate share hospitals will receive 100% of its Medicaid cost for low income patients with special needs.